FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004077

Facility Name: AMBASSADOR NURSING CTR

Address: 4900 N. BERNARD (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 583-7130 **Fax #** (773) 583-3929

IDPA ID Number: 362900425001

Date of Initial License for Current Owners: 05/15/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) MARVIN FOX, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	190	Skilled (SNF)	190	69,350	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	190	TOTALS	190	69,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,222	2,097	3,700	28,019	8
9	SNF/PED					9
10	ICF	24,055	804	677	25,536	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,277	2,901	4,377	53,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.22%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/15/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36 and days of care provided 3,697

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	377,376	21,288	15,928	414,592		414,592	1,680	416,272			1
2	Food Purchase		218,706		218,706	(35,471)	183,235	(118)	183,117			2
3	Housekeeping	157,772	33,533		191,305		191,305		191,305			3
4	Laundry	65,540	26,429		91,969		91,969		91,969			4
5	Heat and Other Utilities			135,328	135,328		135,328	984	136,312			5
6	Maintenance	54,276		88,932	143,208		143,208	(11,833)	131,375			6
7	Other (specify):*							212	212			7
8	**TOTAL General Services**	654,964	299,956	240,188	1,195,108	(35,471)	1,159,637	(9,074)	1,150,563			8
	B. Health Care and Programs											
9	Medical Director			24,263	24,263		24,263		24,263			9
10	Nursing and Medical Records	1,604,204	113,179	272,350	1,989,733		1,989,733	6,782	1,996,515			10
10a	Therapy	139,584	740	7,775	148,099		148,099	(505)	147,594			10a
11	Activities	76,772	9,517	4,309	90,598		90,598		90,598			11
12	Social Services	116,371		2,481	118,852		118,852		118,852			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							1,717	1,717			15
16	**TOTAL Health Care and Programs**	1,936,931	123,436	311,178	2,371,545		2,371,545	7,994	2,379,539			16
	C. General Administration											
17	Administrative	249,009		415,727	664,736		664,736	(160,294)	504,442			17
18	Directors Fees											18
19	Professional Services			138,312	138,312		138,312	(18,965)	119,347			19
20	Dues, Fees, Subscriptions & Promotions			87,868	87,868		87,868	(56,786)	31,082			20
21	Clerical & General Office Expenses	144,787	46,190	178,271	369,248		369,248	(81,308)	287,940			21
22	Employee Benefits & Payroll Taxes			552,470	552,470	35,471	587,941		587,941			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,409	7,409		7,409	(663)	6,746			24
25	Other Admin. Staff Transportation			1,966	1,966		1,966	(1,412)	554			25
26	Insurance-Prop.Liab.Malpractice			231,655	231,655		231,655	1,148	232,803			26
27	Other (specify):*							16,631	16,631			27
28	**TOTAL General Administration**	393,796	46,190	1,613,678	2,053,664	35,471	2,089,135	(301,649)	1,787,486			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,985,691	469,582	2,165,044	5,620,317		5,620,317	(302,729)	5,317,588			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number AMBASSADOR NURSING CTR #0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,775	72,775		72,775	91,644	164,419			30
31	Amortization of Pre-Op. & Org.			7,994	7,994		7,994	4,408	12,402			31
32	Interest			82,402	82,402		82,402	127,341	209,743			32
33	Real Estate Taxes			250,100	250,100		250,100		250,100			33
34	Rent-Facility & Grounds			363,356	363,356		363,356	(354,921)	8,435			34
35	Rent-Equipment & Vehicles			18,634	18,634		18,634	462	19,096			35
36	Other (specify):*											36
37	TOTAL Ownership			795,261	795,261		795,261	(131,066)	664,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		203,137	505,014	708,151		708,151	(2,345)	705,806			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	31,578			31,578		31,578	(31,578)	0			43
44	TOTAL Special Cost Centers	31,578	203,137	609,039	843,754		843,754	(33,923)	809,831			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,017,269	672,719	3,569,344	7,259,332		7,259,332	(467,718)	6,791,614			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,204	30		9
10	Interest and Other Investment Income	(534)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(118)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,151)	24		19
20	Contributions	(4,685)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,067)	21		24
25	Fund Raising, Advertising and Promotional	(49,001)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,959)	20		28
29	Other-Attach Schedule	(109,756)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (231,067)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(236,651)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (236,651)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (467,718)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

AMBASSADOR NURSING CTR

ID# 0004077

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (27,178)	43	1
2	BANK CHARGES	(13,506)	21	2
3	IL COUNCIL ON LTC - COPE	(2,578)	20	3
4	OUT OF STATE TRAVEL	(366)	25	4
5	ENTERTAINMENT	(175)	20	5
6	UNDOCUMENTED SEMINARS	(250)	24	6
7	MARKETING TRAVEL	(1,062)	25	7
8	CAPITALIZED R&M	(12,204)	06	8
9	MISCELLANEOUS INCOME	(1,995)	21	9
10	MCR PT B W/O	(42,813)	21	10
11	PRIOR YEAR LEGAL	(3,832)	19	11
12	BUILDING CO - REPLACEMENT TAX	(3,798)	21	12
13				13
14				14
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99				99
100				100
101	Total	(109,756)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				1,744		(64)						1,680	1
2	Food Purchase	(118)											(118)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					984							984	5
6	Maintenance	(12,204)				319	52						(11,833)	6
7	Other (specify):*						212						212	7
8	**TOTAL General Services**	(12,321)			1,744	1,303	200						(9,074)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(5,560)	12,342							6,782	10
10a	Therapy			65			(570)						(505)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					1,717							1,717	15
16	**TOTAL Health Care and Programs**			65	(5,560)	14,059	(570)						7,994	16
	C. General Administration													
17	Administrative					59,889		(220,183)					(160,294)	17
18	Directors Fees													18
19	Professional Services	(3,832)				6,128	(156,484)	135,223					(18,965)	19
20	Fees, Subscriptions & Promotions	(60,397)				3,582		29					(56,786)	20
21	Clerical & General Office Expenses	(148,180)	3,798			65,361		(2,287)					(81,308)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,401)				738							(663)	24
25	Other Admin. Staff Transportation	(1,428)				16							(1,412)	25
26	Insurance-Prop.Liab.Malpractice					1,205		(57)					1,148	26
27	Other (specify):*					15,463		1,168					16,631	27
28	**TOTAL General Administration**	(215,238)	3,798			152,382	(156,484)	(86,107)					(301,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(227,559)	3,798	65	(3,816)	167,744	(156,854)	(86,107)					(302,729)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	24,204	57,148			3,340		6,952					91,644	30
31	Amortization of Pre-Op. & Org.		4,408										4,408	31
32	Interest	(534)	125,870			897		1,108					127,341	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(363,356)			8,435							(354,921)	34
35	Rent-Equipment & Vehicles						462						462	35
36	Other (specify):*													36
37	**TOTAL Ownership**	23,670	(175,930)			12,672	462	8,060					(131,066)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			7,120	(9,465)								(2,345)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(27,178)					(4,400)						(31,578)	43
44	**TOTAL Special Cost Centers**	(27,178)		7,120	(9,465)		(4,400)						(33,923)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(231,067)	(172,132)	7,185	(13,281)	180,416	(160,792)	(78,047)					(467,718)	45

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 363,356	Ambassador Building Partnership		$	$ (363,356)	1
2	V	32	Mortgage interest		Ambassador Building Partnership		125,870	125,870	2
3	V	31	Amortization Expense		Ambassador Building Partnership		4,408	4,408	3
4	V	30	Depreciation expense		Ambassador Building Partnership		57,148	57,148	4
5	V	21	Replacement Tax		Ambassador Building Partnership		3,798	3,798	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 363,356			$ 191,224	$ * (172,132)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 4,470	Advanced Therapy and Rehab, LLC	100.00%	$ 4,535	$ 65	15
16	V	39	ANCILLARY REHAB	487,672	Advanced Therapy and Rehab, LLC	100.00%	494,792	7,120	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 492,142			$ 499,327	$ * 7,185	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 15,645	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 6,180	$ (9,465)	15
16	V	10	MEDICAL SUPPLIES	6,308	QUALITY CARE MEDICAL SUPPLY	100.00%	748	(5,560)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	1,744	1,744	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,953			$ 8,672	$ * (13,281)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 984	$ 984	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	319	319	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,024	5,024	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,318	7,318	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,717	1,717	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,055	4,055	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,619	12,619	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,923	4,923	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,899	10,899	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,434	6,434	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,446	8,446	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,531	10,531	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,982	1,982	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,128	6,128	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,582	3,582	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	62,443	62,443	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,918	2,918	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	738	738	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	16	16	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,205	1,205	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	15,463	15,463	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,340	3,340	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	897	897	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,435	8,435	38
39	Total			$			$ 180,416	$ * 180,416	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	462	$ 462	15
16	V	19	CORP ALLOC/MGMT FEE	156,484	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(156,484)	16
17	V	6	REPAIRS AND MAINT.	312	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	364	52	17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	49	49	18
19	V	10	NURSE CONSULTANT		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			19
20	V	1	DIETICIAN SALARIES	1,275	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,211	(64)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	163	163	21
22	V	10A	RESPIRATORY THERAPIST	570	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(570)	22
23	V	43	MARKETING CONSULTANT	4,400	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(4,400)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 163,041			$ 2,249	$ * (160,792)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	QUALITY CARE MANAGEMENT	100.00%	$ (57)	$ (57)	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	4,772	4,772	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,381	3,381	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,391	1,391	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	739	739	19
20	V	19	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	156,484	156,484	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	29	29	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	(2,287)	(2,287)	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,168	1,168	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	6,952	6,952	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,108	1,108	25
26	V								26
27	V								27
28	V	17	CORPORATE ALLOCATION	229,727	QUALITY CARE MANAGEMENT	100.00%		(229,727)	28
29	V	19	COMPUTER SERVICES	22,000	QUALITY CARE MANAGEMENT	100.00%		(22,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 251,727			$ 173,680	$ * (78,047)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Admin. Consultant	Administrative	50.00%	See attached	7.5	13.64%	Facility Salary	$ 97,266	17-1	1
2	David Meisels	Exec. Administrator	Administrative	50.00%	See attached	7.5	13.64%	Mgmt fees	64,000	17-3	2
3	Joseph Meisels	Relative	Administrative	0	See attached	2.9	5.80%	Alloc Salary	1,391	17-7	3
4	Brucha Teitelbaum	Relative	Administrative	0	See attached	0.72	1.80%	Alloc Salary	3,381	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 166,038		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						4,535	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						494,792	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 499,327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						6,180	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						748	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						1,744	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 8,672	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	22,033	$ 984	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		22,033	319	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	22,033	5,024	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	22,033	7,318	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		22,033	1,717	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	22,033	4,055	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	22,033	12,619	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	22,033	4,923	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	22,033	10,899	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	22,033	6,434	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	22,033	8,446	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	22,033	10,531	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	22,033	1,982	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		22,033	6,128	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		22,033	3,582	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	22,033	62,443	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	22,033	2,918	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		22,033	738	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		22,033	16	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		22,033	1,205	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		22,033	15,463	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		22,033	3,340	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		22,033	897	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		22,033	8,435	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 180,416	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		22,033	462	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784	312	364	3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994		312	49	4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	1,275	1,211	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		1,275	163	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 2,249	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	PATIENT DAYS	152,042	5	$ (394)	$ (394)	22,033	$ (57)	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	152,042	5	32,933	32,933	22,033	4,772	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	152,042	5	23,333	23,333	22,033	3,381	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	152,042	5	9,600	9,600	22,033	1,391	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	152,042	5	5,097		22,033	739	5
6	19	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	857,602			156,484	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	152,042	5	200		22,033	29	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	152,042	5	(15,781)		22,033	(2,287)	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	152,042	5	8,058		22,033	1,168	9
10	30	DEPRECIATION	PATIENT DAYS	152,042	5	47,971		22,033	6,952	10
11	32	INTEREST	PATIENT DAYS	152,042	5	7,643		22,033	1,108	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 976,262	$ 65,472		$ 173,680	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Continental Care	X		Mortgage			$	$ 430,590			$ 30,647	1
2	Boatmen's Bank		X	Mortgage							125,870	2
3												3
4												4
5												5
	Working Capital											
6	DVI		X	Line of Credit				564,135			39,542	6
7												7
8												8
9	TOTAL Facility Related						$	$ 994,725			$ 196,059	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										1,471	10
11	Universal		X	Insurance							10,572	11
12	Medical Staffing Network		X								1,563	12
13	Thermotech/Prof Med		X								78	13
14	TOTAL Non-Facility Related						$	$			$ 13,684	14
15	TOTALS (line 9+line14)						$	$ 994,725			$ 209,743	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,203 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocated from Boulevard	X					$	$			$ 897	1
2	Allocated from Quality Care	X									1,108	2
3	Interest Income										(534)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,471	21

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 232,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 230,900	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,100)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 251,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 250,100	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	205,799	8
	1998	209,453	9
	1999	208,047	10
	2000	225,047	11
	2001	230,900	12

2002 accrual-2001 taxes 230,900 x 1.085 = 250,000 (after rounding)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBASSADOR NURSING CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-11-418-021	Long term care property	$ 20,374.65	$ 20,374.65
2.	13-11-418-022	Long term care property	$ 74,884.31	$ 74,884.31
3.	13-11-418-026	Long term care property	$ 95,203.27	$ 95,203.27
4.	13-11-418-028	Long term care property	$ 36,775.91	$ 36,775.91
5.	13-11-418-033	Long term care property	$ 3,661.62	$ 3,661.62
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 230,899.76	$ 230,899.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AMBASSADOR NURSING CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,497 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 176,304
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 12,402
4. Dates Incurred: _____

Nature of Costs: Mortgage Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 127,394	1
2					2
3	TOTALS			$ 127,394	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	820		20	-		820	9
10	Various			1984	11,000		20	-		11,000	10
11	Various			1986	44,252		20	2,329	2,329	37,597	11
12	Various			1987	5,800		20	290	290	4,495	12
13	Various			1988	1,825		20	58	58	831	13
14	Various			1990	48,352		20	1,708	1,708	20,951	14
15	Various			1991	1,571		20	79	79	889	15
16	Various			1992	8,653		20	432	432	4,498	16
17	Various			1993	55,217		20	2,761	2,761	30,931	17
18	Various			1994	8,007		20	401	401	3,131	18
19	Various			1995	35,063		20	1,753	1,753	12,878	19
20	Various			1996	120,434		20	6,022	6,022	39,619	20
21	Various			1997	37,040		20	1,853	1,853	10,023	21
22	Various			1998	127,674		20	6,383	6,383	26,725	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,730,841	57,822		57,822		1,469,034	68
69	Financial Statement Depreciation			25,497			(25,497)		69
70	TOTAL (lines 4 thru 69)		$ 2,236,549	$ 83,319		$ 81,891	$ (1,428)	$ 1,673,422	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,236,549	$ 83,319		$ 81,891	$ (1,428)	$ 1,673,422	1
2	FIRE ALARM WORK	1999	1,825		20	91	91	364	2
3	FENCE	1999	580		20	29	29	116	3
4	DOOR DETECTOR	1999	1,975		20	99	99	396	4
5	FIRE PROOFING	1999	3,200		20	160	160	640	5
6	HEATING WORK	1999	2,117		20	106	106	424	6
7	ELEV WORK	1999	1,929		20	96	96	376	7
8	FIRE DOOR	1999	1,120		20	56	56	210	8
9	EXHAUST FAN PARTS	1999	2,562		20	128	128	469	9
10	OVERHEAD DOOR	1999	4,160		20	208	208	745	10
11	VACUUM BRKRS/KITCHEN	1999	864		20	43	43	154	11
12	VACUUM BRKRS/LDRYRM	1999	777		20	39	39	140	12
13	SINK	1999	702		20	35	35	125	13
14	FLOORING	1999	1,155		20	58	58	203	14
15	INSTALL SINK	1999	850		20	43	43	151	15
16	EX FANS & MOTORS	1999	1,817		20	91	91	319	16
17	HOT WATER VALVE	1999	1,964		20	98	98	343	17
18	ELEV FLOORING	1999	1,161		20	58	58	203	18
19	SHED	1999	2,847		20	142	142	497	19
20	WIRING	1999	1,225		20	61	61	219	20
21	GATES	1999	1,056		20	53	53	181	21
22	WIRING	1999	1,741		20	87	87	297	22
23	FIRE DOORS	1999	2,702		20	135	135	450	23
24	INST HANDRAILS	1999	1,600		20	80	80	267	24
25	HANDRAILS	1999	3,226		20	161	161	537	25
26	HANDRAILS	1999	8,652		20	433	433	1,443	26
27	WALLPAPER	1999	5,943		20	297	297	990	27
28	CEILING TILE	1999	1,706		20	85	85	283	28
29	HOT WATER PUMP	1999	1,111		20	56	56	182	29
30	PUMP & TANK SYSTEM	1999	1,562		20	78	78	254	30
31	INST HANDRAILS	1999	520		20	26	26	82	31
32	FLOORING	1999	21,896		20	1,095	1,095	3,468	32
33	ELECTRIC SERV	1999	800		20	40	40	130	33
34	TOTAL (lines 1 thru 33)		$ 2,321,894	$ 83,319		$ 86,158	$ 2,839	$ 1,688,080	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,321,894	$ 83,319		$ 86,158	$ 2,839	$ 1,688,080	1
2	DOUBLE DOORS	1999	1,275		20	64	64	208	2
3	DOOR CHECKS	1999	1,584		20	79	79	263	3
4	NURSING CALL SYS	1999	598		20	30	30	103	4
5	BOILER REHAB	1999	1,605		20	80	80	273	5
6	DIESEL REHAB	1999	1,600		20	80	80	280	6
7	5-FANS	1999	1,675		20	84	84	301	7
8	ELECTCL BOX & WIRE	1999	1,808		20	90	90	293	8
9	SPRINKLER	1999	1,352		20	68	68	215	9
10	DRAPERIES	1999	27,981		20	1,399	1,399	4,318	10
11	PAINTING & DECORAT	1999	14,612		20	731	731	2,254	11
12	FENCE	2000	2,644		20	226	226	609	12
13	RANDEL ELECT	2000	16,761		20	430	430	1,200	13
14	FENCE	2000	2,613		20	223	223	602	14
15	WIRING	2000	23,500		20	603	603	1,683	15
16	SMOKE DETECTORS	2000	1,817		20	47	47	131	16
17	REPAIR SUN PORCH	2000	2,500		20	64	64	152	17
18	CHILLER REPAIR	2000	3,903		20	100	100	238	18
19	A/C	2000	900		20	23	23	55	19
20	ROOM SIGNS	2000	1,695		20	43	43	113	20
21	LAWN FAUCETS	2000	1,557		20	40	40	92	21
22	CITY SCREEN	2000	1,068		20	27	27	62	22
23	PLUMBING	2000	1,196		20	31	31	68	23
24	WATER LINE	2000	809		20	21	21	46	24
25	URINALS	2000	612		20	16	16	37	25
26	RANDEL	2000	1,030		20	26	26	53	26
27	FENCE	2000	988		20	84	84	228	27
28	LOCKS	2000	550		20	28	28	56	28
29	PLUMBING	2000	1,206		20	60	60	120	29
30	PLUMBING	2000	1,101		20	55	55	110	30
31	PLUMBING	2000	932		20	47	47	94	31
32	PAINTING & DECOR	2000	993		20	50	50	100	32
33	GFI RECEPTACLE	2000	657		20	33	33	66	33
34	TOTAL (lines 1 thru 33)		$ 2,445,016	$ 83,319		$ 91,140	$ 7,821	$ 1,702,503	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,445,016	$ 83,319		$ 91,140	$ 7,821	$ 1,702,503	1
2	SPRINKLER	2000	713		20	36	36	72	2
3	DOORS	2000	965		20	48	48	96	3
4	PLUMBING	2000	1,191		20	60	60	120	4
5	PLUMBING	2000	807		20	40	40	80	5
6	SPRINKLERS	2000	535		20	27	27	54	6
7	ELECTRICAL	2000	519		20	26	26	52	7
8	FAUCETS	2000	1,101		20	55	55	110	8
9	PLUMBING	2000	847		20	42	42	84	9
10	SPRINKLER	2000	1,225		20	61	61	122	10
11	FAN COIL	2000	953		20	48	48	96	11
12	TOWER FAN	2000	1,016		20	51	51	102	12
13	PLUMBING	2000	503		20	25	25	50	13
14	DOORS	2000	670		20	34	34	68	14
15	WALK-IN FREEZER	2000	521		20	26	26	52	15
16	FIREPROOF WALLS	2000	550		20	28	28	56	16
17	FAN MOTOR	2000	1,276		20	64	64	128	17
18	TOILET	2000	698		20	35	35	70	18
19	FIRE ALARM	2000	528		20	26	26	52	19
20	FIRE SYSTEM HORN	2000	700		20	35	35	70	20
21	SMOKE DETECTORS	2000	1,224		20	61	61	122	21
22	FIRE STOPPERS	2001	3,639		20	93	93	182	22
23	INSTALL FIRESTOPPING	2001	16,950		20	435	435	779	23
24	INSTALL SPEAKERS	2001	850		20	22	22	39	24
25	INSTALL FIRESTOPPING	2001	21,850		20	560	560	1,003	25
26	SLOT SIGNS	2001	1,968		20	50	50	85	26
27	FURNISH & INSTALL LT	2001	775		20	20	20	34	27
28	FIRE STOPPERS	2001	1,819		20	47	47	76	28
29	BUILDING FIREWALL	2001	1,525		20	39	39	70	29
30	REPLACE COOLING TOWE	2001	15,650		20	401	401	652	30
31	CONCRETE FRONT ENTNC	2001	6,500		20	167	167	202	31
32	INSTALL EXT EXIT SGN	2001	2,019		20	52	52	63	32
33	ANTENNA W/SIGNALLING	2001	2,141		20	55	55	66	33
34	TOTAL (lines 1 thru 33)		$ 2,537,244	$ 83,319		$ 93,909	$ 10,590	$ 1,707,410	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,537,244	$ 83,319		$ 93,909	$ 10,590	$ 1,707,410	1
2	INSTALL MOTOR PUMP	2001	1,100		20	28	28	32	2
3	SECURITY & ALRM SYST	2001	1,011		20	26	26	29	3
4	REPAIR FIRE ALARM	2001	1,469		20	38	38	40	4
5	BOILER REPAIR	2001	1,853		20	48	48	90	5
6	INSTALL MOTOR PUMP	2001	1,324		20	34	34	35	6
7	FURNISH & INSTALL BL	2001	620		20	31	31	52	7
8	CUBICLE CURTAIN	2001	2,296		20	115	115	163	8
9	FIRESTOPPER	2001	565		20	28	28	54	9
10	MOTOR WORK	2001	824		20	41	41	75	10
11	FIRE PUMP	2001	664		20	33	33	61	11
12	CUBICLE CURTAIN	2001	721		20	36	36	66	12
13	CONDENSOR CHILLER	2001	1,011		20	51	51	89	13
14	LAMPS	2001	654		20	33	33	50	14
15	CARPET SEAM WORK	2001	525		20	26	26	39	15
16	HOT WATER VALVE SEAL	2001	517		20	26	26	37	16
17	INSTALL FAUCETS	2002	648		20	54	54	54	17
18	INSTALL FAUCETS	2002	1,780		20	148	148	148	18
19	INSTALL SMOKE/FIRE DAMPER	2002	1,170		20	88	88	88	19
20	CONCRETE RESTORATION	2002	4,575		20	305	305	305	20
21	WALK IN FREEZER	2002	2,420		20	141	141	141	21
22	MASONRY	2002	2,750		20	138	138	138	22
23	POST TERMINAL/BATTERY CABLE GENERATOR	2002	850		20	7	7	7	23
24	WATER PUMP - GENERATOR	2002	1,216		20	5	5	5	24
25	FIRE ALARM	2002	592		20	30	30	30	25
26	TILES	2002	1,053		20	53	53	53	26
27	COOLING SYSTEM	2002	4,287		20	214	214	214	27
28	PAINTING	2002	2,725		20	136	136	136	28
29	CALL SYSTEM	2002	516		20	26	26	26	29
30	RECEPTACLES	2002	600		20	30	30	30	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	1
2									2
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4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,577,580	$ 83,319		$ 95,878	$ 12,559	$ 1,709,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1977	$ 1,714,426	$ 57,148	35	$ 57,148	$	$ 1,457,267	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Ambassador Building Partnership			1980	3,109		20			3,109	9
10	Ambassador Building Partnership			1981	7,984		20			7,984	10
11											11
12											12
13	Allocated from Boulevard Healthcare			2002	5,322	674	20	674		674	13
14											14
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,730,841	$ 57,822		$ 57,822	$	$ 1,469,034	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 563,746	$ 42,459	$ 63,286	$ 20,827	10	$ 321,652	71
72	Current Year Purchases	52,730	14,437	5,255	(9,182)	10	5,255	72
73	Fully Depreciated Assets	408,039				10	408,039	73
74								74
75	TOTALS	$ 1,024,515	$ 56,896	$ 68,541	$ 11,645		$ 734,946	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,729,489	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 140,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 164,419	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,204	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,444,643	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 21,006	92
93			93
94			94
95		$ 21,006	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Boulevard Healthcare Management Allocation				8,435			6
7	TOTAL				$ 8,435 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 19,096 Description: Copier-$14,850; Ice/Water machine-$2411;Postage-$1373;Alloc Boulevard-$462
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 52,303	$		$ 52,303	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			30,580			30,580	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			422,131			422,131	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				120,197		120,197	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						82,940		82,940	13
14	TOTAL			$		$ 505,014	$ 203,137		$ 708,151	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (17,079)	$	1
2	Cash-Patient Deposits	66,059		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,342,070		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,496		6
7	Other Prepaid Expenses	75,390		7
8	Accounts Receivable (owners or related parties)	182,834		8
9	Other(specify): See Supplemental Schedule	304,130		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,056,900	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	684,155		15
16	Equipment, at Historical Cost	789,309		16
17	Accumulated Depreciation (book methods)	(835,861)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,995		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	21,006		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 664,604	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,721,504	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,285,401	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,057		28
29	Short-Term Notes Payable	994,725		29
30	Accrued Salaries Payable	89,063		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,128		31
32	Accrued Real Estate Taxes(Sch.IX-B)	251,200		32
33	Accrued Interest Payable	5,764		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	180,024		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,899,362	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,899,362	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (177,858)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,721,504	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (96,212)	1
2	Restatements (describe):		2
3	**Rounding**	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (96,217)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(31,641)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (81,641)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (177,858)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,991,407	1
2	Discounts and Allowances for all Levels	(1,113,327)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,878,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,074,706	6
7	Oxygen	12,918	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,087,624	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	140,687	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,481	19
20	Radiology and X-Ray	1,385	20
21	Other Medical Services	87,951	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 255,504	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	534	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 534	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,949	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,949	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,227,691	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,195,108	31
32	Health Care	2,371,545	32
33	General Administration	2,053,664	33
	B. Capital Expense		
34	Ownership	795,261	34
	C. Ancillary Expense		
35	Special Cost Centers	739,729	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,259,332	40
41	**Income before Income Taxes (line 30 minus line 40)****	(31,641)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (31,641)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,815	2,435	$ 62,811	$ 25.79	1
2	Assistant Director of Nursing	676	721	17,785	24.67	2
3	Registered Nurses	25,933	28,522	578,397	20.28	3
4	Licensed Practical Nurses	9,008	9,809	191,136	19.49	4
5	Nurse Aides & Orderlies	70,045	75,721	730,914	9.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,987	10,900	139,584	12.81	8
9	Activity Director	1,833	2,258	29,901	13.24	9
10	Activity Assistants	5,415	5,819	46,871	8.06	10
11	Social Service Workers	4,896	5,440	116,371	21.39	11
12	Dietician					12
13	Food Service Supervisor	7,293	8,103	123,568	15.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,497	35,201	253,808	7.21	15
16	Dishwashers					16
17	Maintenance Workers	1,930	2,126	54,276	25.52	17
18	Housekeepers	19,822	21,388	157,772	7.38	18
19	Laundry	8,711	9,186	65,540	7.14	19
20	Administrator	2,013	2,406	108,540	45.12	20
21	Assistant Administrator	1,800	2,774	43,203	15.58	21
22	Other Administrative	3,084	3,325	97,266	29.25	22
23	Office Manager					23
24	Clerical	10,520	11,592	144,787	12.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,335	1,476	23,161	15.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,836	2,040	31,578	15.48	33
34	TOTAL (lines 1 - 33)	220,450	241,241	$ 3,017,269 *	$ 12.51	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	360	$ 15,928	01-03	35
36	Medical Director	125	24,263	09-03	36
37	Medical Records Consultant	83	4,696	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	163	6,520	10-03	39
40	Physical Therapy Consultant	109	4,515	10a-03	40
41	Occupational Therapy Consultant	72	3,260	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,309	11-03	44
45	Social Service Consultant	48	2,481	12-03	45
46	Other(specify)				46
47	Wound Care Consultant	139	17,422	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,194	$ 83,394		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	83	$ 4,958	10-03	50
51	Licensed Practical Nurses	5,283	238,754	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,366	$ 243,712		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurel Whitney (1/1-7/1)	Administrator	0	$ 65,900
Aaron Butcher (4/19-12/31)	Administrator	0	42,640
Patricia Correa	Asst Administrator	0	43,202
David Meisels	Exec Administrator	50	97,266
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 249,009

B. Administrative - Other

Description	Amount
Quality Care Management	$ 229,727
Olympia Group LLC	122,000
David Meisels	64,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 415,727

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 28,966
DVI	Accounting	3,151
Econocare	Purchasing Consultant	175
Personnel Planners	Unemployment Consultant	1,285
See attached	Legal	67,795
See attached	Computer	32,803
Documentation Solutions	Billing Services	700
Bridgemark, LLC	Compliance Consulting	1,738
Achieve Accreditation	JCAHO Consultant	1,700
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 138,312

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,840
Unemployment Compensation Insurance	35,137
FICA Taxes	212,541
Employee Health Insurance	191,446
Employee Meals	35,471
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	5,886
Holiday Expense	2,710
401K Expense	4,726
Disability Insurance	2,458
Employee Benefits	22,748
Union Pension	8,669
Employee Life Insurance	309
TOTAL (agree to Schedule V, line 22, col.8)	$ 587,941

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	13,170
Health Care Worker Background Check	412
(Indicate # of checks performed 41)	
ICLTC	8,157
Advertising & Promotion	49,001
Dues, Permits Licenses	5,532
Yellow pages	3,959
Allocated from Boulevard	3,582
Allocated from Quality	29
Less: Public Relations Expense	( )
Non-allowable advertising	(49,001)
Yellow page advertising	(3,959)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,008
Allocated from Boulevard	738
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,746

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number AMBASSADOR NURSING CTR # 0004077 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $10,735**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,244** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **104,025**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,471** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees